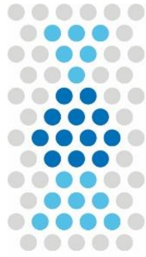

NEW YORK

MATTERS

Medication Assisted Treatment & Emergency Referrals

Data collection for SUD treatment facilities

Please complete this data collection form if you intend on participating in the MATTERS network in the future. This does not commit you/your organization to participating, it simply allows for planning to continue. If your hospital/treatment organization has multiple locations, please complete one form for each location.

Facility Name ____

Address ____

Phone _______________________________

Contact Name _________________________ Contact Title ___________________________

Contact E-mail (company email preferred) ____

Estimated number of waived (X number) providers _____ MD/DO ________PA/NP

Fax (must be in a secure location – for referring emergency departments, the fax

near the ER secretary/nurse's station is ideal) ____

Availability of peer support at your hospital/clinic? ____

Do you also offer any of the following? Methadone__________ Naltrexone __________

Any insurance type not accepted? ____

Do you accept those without insurance? ____

Do you have access to a facilitated enroller? ____

Do you offer telemedicine visits? ____

Below, please indicate how many patients per day of the week you anticipate your site being able to accept from the referral network (no commitment here yet)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Additional comments/concerns:

____

____